MediDrive

Mileage Reimbursement Trip Log and Invoice

DRIVER INFORMATION				
Driver's Name		Driver's Street Address		
Driver's License #	Driver's License State	City	State	Zip Code

RECORD OF TRIPS

The treating facility must certify that the member attended the appointment(s) as indicated. False information may result in reporting to regulatory agencies. Requests must include trips within the same calendar week. Utilization may be reviewed, and fraudulent activity will result in the denial of reimbursement. Mileage is subject to validation and adjustment. Supporting documentation must be retained and provided upon request.

	TRIP DATE	TRIP NUMBER	TRIP TYPE		FACILITY PHONE NUMBER	PHYSICIAN/CLINICIAN NAME + SIGNATURE** (Please print name and sign)
1			☐ Round Trip	☐ One-way		
2			☐ Round Trip	☐ One-way		
3			☐ Round Trip	☐ One-way		
4			☐ Round Trip	☐ One-way		
5			☐ Round Trip	☐ One-way		
6			☐ Round Trip	☐ One-way		
7			☐ Round Trip	☐ One-way		

*For California members: Per All Plan Letter 17-010 from the California Department of Health Care Services, Medi-Cal beneficiaries who drive themselves to their appointment are NOT eligible for mileage reimbursement.
**I certify that this patient was seen for a Medicaid covered health service

SIGNATURE OF DRIVER		MEMBER INFORMATION	SIGNATURE OF MEMBER	
I certify that I provided the listed transportation as documented and meet all legal requirements to operate a vehicle. I attest the trips were completed as described, are not duplicated, and no other reimbursement has been or will be sought. I understand payment is subject to validation and false information may result in denial, recovery, or further action.		Relationship to Member Member Name	I certify that the information provided is true, accurate, and complete, and that the listed transportation services were received as described. I attest that no duplicate reimbursement has been requested or received. I understand that false or misleading information may result in denial of reimbursement and potential referral for investigation.	
Driver's Name	Date	Member ID	Member Signature	Date

SEND COMPLETED FORMS TO:

MediDrive 1801 California St. Suite 2400 Denver CO 80202 / EMAIL: **claimsco@medidrive.com**

Please allow 4-6 weeks for payment processing. For any claim questions, call **720-844-9610**